

Definite risk factors for melanoma include white race, particularly those of Celtic heritage; sun exposure, particularly with episodes of sunburn; dysplastic nevi, particularly familial dysplastic nevi; and large congenital nevi (greater than 20 cm).

Patients should be encouraged to report any change in a skin lesion, particularly recent growth, bleeding, pain, or the development of a new lesion. Physicians should remove or take a biopsy of any skin lesion that is at all suggestive of melanoma.

Physicians should be vigilant in screening for melanoma and should keep in mind the rule of "ABCD": *Asymmetry*, *Border irregularity*, *Color variegation*, and *Diameter* generally greater than 6 mm. Various textbooks and monographs are available to assist physicians in recognizing melanoma in its earliest stages.

The familial dysplastic nevus syndrome is an autosomal dominant condition with a lifetime incidence of melanoma approaching 100%. Dysplastic nevi tend to be more plentiful (25 to 75 per person) and larger (6 to 15 mm) than common nevi. Dysplastic nevi are acquired after birth and often have irregular borders, variegated colors (particularly tan, brown, and pink), and indistinct borders fading into the adjacent normal skin.

Primary prevention includes avoiding sunlight, using protective clothing and hats, and using sunscreens as early as infancy and throughout adult life. Sunbathing and the use of tanning parlors should be actively discouraged. The melanoma epidemic is presenting all primary care physicians with the challenge of the primary prevention of the disease and the early detection of melanoma at a time when it is completely curable.

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Silent Myocardial Ischemia

ALTHOUGH MYOCARDIAL ISCHEMIA AND INFARCTION are major health problems in the western world, our understanding of this disease remains incomplete. Physicians think of ischemic heart disease as a clinical syndrome manifested by chest pain or other "anginal equivalents." The cardiologic literature over the past decade has clearly shown, however, that silent myocardial ischemia is a common manifestation of coronary artery disease. In fact, there is every reason to think that silent myocardial ischemia carries the same (or worse) clinical significance as symptomatic coronary artery disease. This should come as no surprise because one of five sudden death victims in the United States has no history of heart disease, yet commonly has evidence of advanced atherosclerotic disease in the coronary arteries at autopsy.

Silent myocardial ischemia has been studied predominantly using two tools: ambulatory Holter electrocardiographic monitoring and the exercise test. Although factors that make myocardial ischemia painless in some persons are not completely understood, it is a common phenomenon. In a study of patients with angina with known coronary artery disease documented by arteriography, 75% of all ambulatory episodes of ischemia were painless. Silent myocardial ischemia shares the same circadian variations as angina pectoris

and myocardial infarction, occurring most often in the morning, generally between 0600 and 1200. Silent myocardial ischemia, however, seems to develop more commonly at rest and at lower levels of heart rate and blood pressure. This suggests, but does not prove, that silent myocardial ischemia may be due to enhanced coronary artery vasoconstriction, as opposed to an increase in myocardial oxygen demand.

Although it is becoming clear that the problem of silent myocardial ischemia is one of major proportions, the solution is less clear. Cohn recommends screening exercise tests in all patients with two or more major risk factors for coronary artery disease, particularly those with diabetes mellitus because of visceral neuropathy. Patients with abnormal results on treadmill tests, but ST depression less than 2 mm in stage I or II of the Bruce protocol, should have radionuclide imaging. The decision to proceed to coronary arteriography depends on the patient. In general, patients suffering a myocardial infarction undergo exercise testing, usually at least two to three weeks after the infarction. Silent myocardial ischemia in patients with stable angina pectoris is often best detected by ambulatory Holter monitoring.

Currently there is no reason to treat silent myocardial ischemia any differently than symptomatic angina pectoris. Risk factors should be modified to the extent possible. The decision to proceed to arteriography and ultimately angioplasty or coronary artery bypass grafting must be tailored to each patient. In patients who have suffered a myocardial infarction and subsequently show silent myocardial ischemia, many data suggest a long-term benefit with β -blocker therapy. Patients with angina pectoris and silent myocardial ischemia are subject to vasospasm and therefore may benefit from using calcium channel blockers, as well as nitrates and β -blockers.

In the forthcoming years, much new information will surface regarding silent myocardial ischemia. Because of the extent of this public health problem, primary care physicians should make every effort to keep abreast of new developments in the diagnosis and treatment of the disorder.

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Fluoroquinolones

THE FLUOROQUINOLONES are a remarkable new group of bactericidal antibiotics related to nalidixic acid. Among other effects, they appear to act on DNA gyrase, an enzyme involved in DNA replication. The agents currently available in the United States include norfloxacin and ciprofloxacin. Because these agents show a wide spectrum of bactericidal activity and an apparently excellent safety profile, they can be extremely effective agents in a primary care practice but must be used wisely.

The spectrum of antibacterial activity of these agents includes *Escherichia coli*, *Klebsiella*, *Hemophilus influenzae* (including ampicillin-resistant strains), meningococci, *Branhamella catarrhalis*, *Salmonella*, *Shigella*, *Campylobacter jejuni*, *Aeromonas*, *Yersinia enterocolitica*, staphylococci (including methicillin-resistant *Staphylococcus aureus*), and *Pseudomonas aeruginosa*.

Norfloxacin and ciprofloxacin have been shown to be effective for the treatment of genitourinary and gastrointes-